	it of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CI.IA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
90C#	<i>:</i>)	445256	B. WING		11/15/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	(*)
HARTS\	VILLE CONVALESCEN	TCENTER	- 1	GAO MCMURRY BLVD HARTSVILLE, TN 37074	* * *
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLET DATE
F 000	INITIAL COMMENT	S	F 000		
	Center. No deficience complaint investigation were for the Recertif PART 483, Requirer Facilities. NOTIFY OF CHANG (INJURY/DECLINE/ICFR(s): 483.10(g)(1)(g)(14) Notification of Consult with the residence on the consult with the residence of the consults in injury and from the consults in intervention (B) A significant charmental, or psychosocideterioration in health status in either life-th clinical complications (C) A need to after the a need to discontinued.	were completed on at Hartsville Convalescent cles were cited relatied to ion #42720. Deficiencies fication survey under 42 CFR ments for Long Term Care SES ROOM, ETC) 4) f Changes, mediately inform the resident; dent's physician; and notify, r her authority, the resident en there is ving the resident which has the potential for requiring in; high interest (that is, a h, mental, or psychosocial reatening conditions or i); eatment significantly (that is, a h existing form of erse consequences, or to an of treatment); or	F 157	F 157 Our facility will inform the resident; consult with the resident's Dr; and notify, consistent with his/her authority, the resident representative(s) when there is- a, an accident involving the resident which results in injury and has the potential for requiring Dr, intervention; b, a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); c, a need to after treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commerce a new form of treatment); or d, a decision to transfer of discharge the resident from the facility must ensure that all pertinent information specified in 483.15(c)(1)(ii) when making notification unde (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in 483.1.0(c)(2) is available & provided upon request to the Dr. (iii) our facility must also promptly notify the resident and the resident representative, if any, when there is- a, a change in room or roommate assignment as specified in 483.10(c)(or b, a change in resident rights under Federal or State law or regulations as specified in paragrap (e)(10) of this section. (iv) the facility will recon and periodically update the address (mailing & email) & phone number of the resident representative(s)	6):
	§483,15(c)(1)(ii).		ATUDE	TITI,E	(X6) DATE
RATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGN	() J	total	2-6-
saloguar	ds provide sufficient profe	citon to the batients, (see instructions	In Discount of	ion may be excused from correcting providing it is described above are discluded the state of correction are safety and plans of correction are safety and plans of correction are safety and plans of correction is requisited.	otermined that osable 90 day disclosable 14

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	ų.	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE			
	ILLE CONVALESCEN	T CENTER		649 MCMURRY BLVD HARTSVILLE, TN 37074				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		(I) PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	DE I	COMPLETION DATE		
F 157	Continued From pa (ii) When making not (14)(i) of this section all pertinent informations available and prophysician. (iii) The facility must resident and the facility must update the addression phone number of the facility failed to recommendations for residents reviewed. The findings include Resident #5 was addressed on Binclude and readmitted on Bincluding Type I Diat Diabetes Mellitus, Continuation of the facility failed to make and readmitted on Bincluding Type I Diat Diabetes Mellitus, Continuation of the finding Type I Diat Diabetes Mellitus, Continuation of the facility failed to Bincluding Type I Diat Diabetes Mellitus, Continuation of the finding Type I Diat Diabetes Mellitu	ge 1 clification under paragraph (g) n, the facility must ensure that alion specified in §483,15(c)(2) vided upon request to the class promptly notify the dent representative, if any, and or roommate assignment and the representative of the consum and periodically (malling and email) and consider representative(s). The is not met as evidenced coord review and interview, cotify the Physician of consider the facility on 4/7/04 could be the facility on 4	F1		Ision list the le vision lace a met recommen ing staff w dental & ng the wee it for 3 endations.	thod of idation vill be vision skly		
ic	Obstructive Pulmons	ary Disease, Bipolar Disorder, I Disabilities, Peptic Ulcer			(continue	lon shoet	Page 2 of 16	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/28/2017 FORM APPROVED

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIËR/CLIA IDENTIFICATION NUMBER:		iple construction NG		COMPLETED	
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	PROVIDER OR SUPPLIER	IT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 649 MCMURRY BLVD HARTSVILLE, TN 37074		J.	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X4) COMPLETION DAYE	
	Medcial record revi- Data Set (MDS) da Resident #5 had a l Status score of 3, ir impairment. Contine 6/2/17 and 9/1/17 re impaired vision and lenses. Medcal record revie Resident #5 reveale deficits. Medical record revie Evaluation dated 6/ an eye evaluation to review of an eye ex 6/30/17 revealed a resident to receive ' per day) Daily activ affected. Refer for 0 Medical record revie the Physician had b recommendations n referral been made. Interview with Licen on 11/14/17 at 2:50 station revealed if a Physician was notifi appointment.	ew of the Quarterly Minimum ted 6/2/17 and 9/1/17 revealed Brief Interview for Mental indicating severe cognitive used review of the MDS dated avealed the resident had did not have corrective. Ew of the Care Plan for ed the resident had visual ew of a Request for an Eye 13/17 revealed a request for a be completed. Continued am evaluation completed on recommendation for the "artificial tear tid [three times wities and quality of life Cataract evaluation" Ew revealed no documetation een notified of the for had a cataract evaluation sed Practical Nurse (LPN) #4 PM at the 2nd floor nurses referral was needed the ed and ordered the referral	F 15				
	ovaluation went to the	n revealed an eye exam ne Director of Nursing (DON) nurse, who was responsible	-1		1	Dage 3 of 16	

12 01 11/11/71/7007 PRINTED: 11/28/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. DUILDING B. WING 445256 11/15/2017 STREET ADDRESS, CITY, STATE, 21P CODE NAME OF PROVIDER OR SUPPLIER **649 MCMURRY BLVD** HARTSVILLE CONVALESCENT CENTER HARTSVILLE, TN 37074 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 157 F 157 | Continued From page 3 for contacting the Physician to notify of recommendations. Continued interview revealed documentation of the Physician notification would be in the Nurse's Notes. LPN #1 reviewed Nurse Progress Notes and confirmed there was no documentation of notification to the Physician of the recommendations. LPN #1 confirmed the facility failed to notify the Physician of the eye exam recommendations for a cataract referral and artificial tears for Resident #5. Interview with the DON on 11/14/17 at 5:17 PM in the conference room confirmed the facility failed to ensure the Physician was notified of the eye exam recommendations for a cataract referral or the need for artificial tears for Resident #5. F 241 | DIGNITY AND RESPECT OF INDIVIDUALITY F 241 SS=E | CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and

observation revealed CNA#1 removed a

FORM CMS-2567(02-99) Previous Versions Obsolate

The findings included:

promote the rights of the resident.

residents observed during a meal.

This REQUIREMENT is not met as evidenced

Based on observation and interview, the facility falled to ensure dignity and respect for 5 of 11

Observation of a lunch meal on 11/13/17 between 12:20 PM and 12:40 PM in the 1st floor common area revealed Certified Nurse Alde (CNA) #1 completed tray set-up for 5 residents. Further

Event ID: 4ZDI11

Facility ID; TN6501

If continuation sheet Page 4 of 16

1.55 (2.5) (3.3) (4.4) (4.4)

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	COMPLETED	
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NAME OF PROVIDER OR SUPPLIER 11ARTSVILLE CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 649 MCMURRY BLVD HARTSVILLE, TN 37074		
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	hand and placed the each resident. Cont CNA #/2 completed in Further observation sandwich from a plat hand and placed it of the 1st floor nurses removes the sandwich and sometimes sandwich and sometimes they finterview with CNA if the 1st floor nurses completing tray set to removed the sandwich and placed it on the revealed sandwiches a plate. Interview with the Director of the DON expected staff to we touch resident food, the DON expected placed on. After lunch observation the not to touch resident and were not to place DON confirmed the fand respect for 5 resident food to be served on the food to be served on the food to be served to the food to be served the food to the food to be served the food to be served to the food t	astic bag with an ungloved a sandwich on the tray for inued observation revealed a tray set-up for 1 resident. Tevealed CNA #2 removed a astic bag with an ungloved on the tray. #1 on 11/13/17 at 12:45 PM at station revealed she always iches from the bag with an tinued interview revealed hes were served on plates	F 24	F 241 We will trent & care for each resident in a manner & in an environment that promotes maintenance or enhancement of his/her que of life recognizing each resident's individua. Our facility will protect & promote the right. I.CNA's will be in-serviced on the appropriate way to set up a resident's tray & instructed must always wear gloves if they touch any food items on a resident's tray. 2. The dictary manager has been instructed sandwiches must always be served on a plat. The dictary department will be in-serviced appropriate way sandwiched should be served. 3. Ment times will be monitored by nursing managers, department managers including to administrator and DON for I month, then in will be given specific meal times & days the have dining room duty. 4. The findings during the meal time monito. Be reviewed during the weekly QAPI/IDT to I month with interventions as needed.	dity ality ality. ality inte they te. 12-31-17 on the red, the panagers ey will ring will	

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(2) MULTIPLE CONSTRUCTION OUILDING		(X3) DATE SURVEY COMPLETED	
	445256 B. WING		(1977) ATTACA	11/15/2017			
	PROVIDER OR SUPPLIER	T CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 649 MCMURRY BLVD HARTSVILLE, TN 37074				
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	Administrator stated inappropriate" The facility failed to ensure residents during a management of the facility failed to ensure sidents during a management of the facility failed to ensure residents. §483.10(i) Safe environment, including the a safe, clean environment, including treatment and support facility must provide facility shall enter the facility shall ent	"that was completely Administrator confirmed the tre dignity and respect for 5 heal. FORTABLE/HOMELIKE (i)(1)(1)(i)(ii) tain and use personal ing furnishings, and clothing, hess to do so would infringe eatth and safety of other ronment. The resident has a comfortable and homelike ing but not limited to receiving outs for daily living safely. vide- omfortable, and homelike ing the resident to use his or ings to the extent possible. uring that the resident can vices safely and that the facility maximizes resident inces not pose a safety risk. exercise reasonable care for resident's property from loss is not met as evidenced ition and interview, the lea home like environment			sing, as ge upon dents, infortable, not for daily afe, clean owing the to the resident the sident . The coss or viate way o never e do plate. ed, lhe ring DT	() ()	

CENTERS FOR MEDICARE & MEDICAID SERVICES			,			7	. 0938-0391
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		18		649	MCMURRY BLVD		
HARTSV	ILLE CONVALESCEN	TCENTER		HAF	RTSVILLE, TN 37074		
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F 252	Continued From parthe findings included Observation of a lur 12:20 PM and 12:40 area revealed Certificompleted tray set-tobservation revealed sandwich from a plathand and placed the resident. Continued completed a tray set observation revealed sandwich from a plathand and placed it of the 1st floor nurses are removed the sandwich and sometimes sandwich and sometimes they interview with CNA fitte 1st floor nurses are completing tray set-tremoved the sandwich and placed it on the revealed sandwiches a plate.	ge 6 ad: ach meal on 11/13/17 between by PM in the 1st floor common ied Nurse Aide (CNA) #1 up for 5 residents, Further d CNA #1 removed a estic bag with an ungloved estic bag with an ungloved to conservation revealed CNA #2 t-up for 1 resident. Further d CNA #2 removed a stic bag with an ungloved in the tray. 41 on 11/13/17 at 12:45 PM at estation revealed she always ches from the bag with an unued interview revealed nes were served on plates were not. 42 on 11/13/17 at 2:45 PM at estation revealed when up for a resident she normally ch with an ungloved hand tray, Further interview es were not always served on		252		RIATE	DATE
6 t t	11/13/17 at 6:05 PM expected staff to wear ouch resident food. The DON expected placed on. Afte unch observation the pot to touch resident.	ector of Nursing (DON) on in her office revealed she ar gloves if they have to Continued interview revealed ates to be provided for food informing the DON of the DON stated the CNAs were food with ungloved hands a food items on the tray. The					Page 7 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/28/2017 FORM APPROVED

THE R. P. LEWIS CO., LANSING,

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10	S	COMPLETED	
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F 252	Continued From particles of the home like environm	facility failed to provide a	F 252			
	7:38 AM in her office food to be served or Administrator of the Administrator stated Inappropriate" The	dministrator on 11/14/17 at expected all provided she expected all properties. After informing the funch observation the "that was completely administrator confirmed the ide a home like environment."				
F 282 SS=D	SERVICES BY QUA CARE PLAN CFR(s): 483.21(b)(3	LIFIED PERSONS/PER)(ii)	≓ 282			
***************************************	(b)(3) Comprehensive The services provide as outlined by the comust-	ve Care Plans ed or arranged by the facility, emprehensive care plan,				
ĺ	care.	ualified persons in In resident's written plan of T is not met as evidenced				
	by: Based on medical re the facility falled to e	ecord review and Interview, nsure a follow-up ained for 1 resident (#5) of				
1.	The findings included	d:				
	and readmilled 8/10/ Type I Diabetes Melli Mellitus, Calaracts, F	lypertension, Peripheral Iema, Arthropathy, Long				

PRINTED: 11/28/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 11/15/2017 445256 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 549 MCMURRY BLVD HARTSVILLE CONVALESCENT CENTER HARTSVILLE, TN 37074 PROVIDER'S PLAN OF CORRECTION (XS) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX | CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 282 F 282 ! Continued From page 8 Atherosclerotic Heart Disease, Chronic Obstructive Pulmonary Disease, Bloolar Disorder, F 282 Moderate Intellectual Disabilities, Peptic Ulcer, The services provided or arranged by the and Gastro-Esophageal Reflux Disease. facility, as outlined by the comprehensive care plan, will -Medical record review of the Quarterly Minimum be provided by qualified person in accordance Data Set (MDS) dated 6/2/17 and 9/1/17 revealed with each resident's written plan of care. the resident had impaired vision and did not have 1. The recommendations made for any eye exams and/or surgeries will be logged by the DON before corrective lenses. giving to the nurse to notify the attending & include in the nurses notes. Medical record review of the Care Plan for 12-31-17 2, The DON will follow up from her log within Resident #5 revealed the resident had visual an appropriate time frame to see that the deficits. recommendations have been followed through with Medical record review of a Request for an Eye 3. The DON will bring her findings to the weekly Evaluation dated 6/13/17 revealed a request for OAPI/IDT weekly meetings eye evaluation to be completed. Continued review 4. The recommendations after the eye clinic visits of an eye exam evaluation dated 6/30/17 will be reviewed during the weekly QAPI/IDT revealed it was recommended for the resident to meeting to ensure interventions were processed receive "...artificial tear tid [three times per appropriately for 3 of the eye clinic visits day]...Dally activities and quality of life affected. Refer for Cataract evaluation..." Medical record review revealed the Physician had not been notified of the recommendations nor had a cataract evaluation referral been made. Interview with Licensed Practical Nurse (LPN) #4 on 11/14/17 at 2:50 PM at the 2nd floor nurses station revealed if a referral was needed the Physician was notified and ordered the referral

FORM CMS-2587(02-99) Previous Versions Obsolate

appointment. LPN #4 stated the nurse was responsible for making the referral appointment

Interview with LPN #1 on 11/14/17 at 5:05 PM in the conference room revealed eye exam

evaluation went to the Director of Nursing (DON) and then to the floor nurse, who was responsible

once ordered by the physician.

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Event ID: 4ZDI11

Facility ID: TN8601

If continuation sheet Page 9 of 16

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENT/(FICATION NUMBER:	1 1	DING		COMPLETED	
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F 371	notification to the PI Nurse's Notes. LPN Notes and confirme documentation of the the recommendation facility failed to notificam recommendation and artificial tears for the conference room to ensure the Physic exam recommendation and for artificial tears for the eneed for artificial tears for the conference room to ensure the Physic exam recommendation and for artificial tears for artificial tears for the physic exam recommendation and the need for artificial tears.	hysician to notify of Continued interview revealed hysician would be in the 1/4/11 reviewed Nurse Progress of there was no be Physician being notified of the physician of the eye tions for a cataract referral or Resident #5. ON on 11/14/17 at 5:17 PM in a confirmed the facility failed claim was notified of the eye tions for a cataract referral or the tears for Resident #5. STORE/PREPARE/SERVE -	F 2	371			
	(i)(1) - Procure food considered satisfact authorities. (i) This may include from local producers and local laws or reg (ii) This provision do facilities from using pardens, subject to case growing and food (iii) This provision do (iii) This provision do	from sources approved or ory by federal, state or local food items obtained directly subject to applicable State gulations. es not prohibit or prevent produce grown in facility compliance with applicable od-handling practices,			e e		
Ė	from consuming food	ds not procured by the facility. e, distribute and serve food in ressional standards for food			788		

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPI,IER/CLIA IDENTIFICATION NUMBER;	I i	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	foods brought to residents to ensure sate handling, and constitutions. This REQUIREMENT by: Based on observation failed to serve sand failed to serve lemo residents; failed to videnting gloves and contaminated glove failed to thoroughly falled to maintain a machine and nouris dispose of expired by applesauce and sand use. The findings include Observation of a lunder to the plastic bag placed the sandwich Continued review revealed CN/from the plastic bag placed the sandwich Continued review retray set up for 1 residents and ungloved has interview with CNA for the 1st floor nurses are moved the sandwich continued	regarding use and storage of sidents by family and other after and sanitary storage, imption. IT is not met as evidenced on and interview, the facility wiches on plates to residents; in squares on plates to the vash or sanitize hands prior to serving food; failed to remove as prior to handling bulk food; dry plate lids prior to use;	F 37	i)(1) Facility will procure food from sour approved or considered satisfactory by festate or local authorities. This may include items obtained directly from local product subject to applicable State & local laws or regulations. This provision does not produce ground facility gardens, subjected to compliance applicable sales growing & food handlin This provision does not procured by the faction of faction of the faction of the faction of	deral. e food ers. r ibit or own in with g practices. s from ility. food in age of ther printe ed dwashing owls c to from viced cked g/	12-31-17	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
\bigcirc		445256	B. WING		44/45/004/4	
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	Interview with CNA and the 1st floor nurses completing tray set or removed the sandwand placed it on the revealed sandwiche plates. Observation of a din between 5:25 PM arcommon area revealed staff to we touch resident food. The DON expected placed on after lunch and dinner observation of the tray. The DON to distribute food in a linterview with the Administrator of the Interview with the Administrator with the	thes were served on plates were not. #2 on 11/13/17 at 2:45 PM at station revealed when up for a resident she normally ich with an ungloved hand tray. Further interview s were not always served on the meal on 11/13/17 at 5:45 PM in the 1st floor led 6 residents were served astic bags without plates. rector of Nursing (DON) on in her office revealed she ar gloves if they have to Continued interview revealed lates to be provided for food or informing the DON of the servation the DON stated the uch resident food with were not to place food items it confirmed the facility failed	F 371	F 371 5. The refrigerator in the nourishment room has since been cleaned. The buttermilk, applesauce & peanut butter sandwiches have been discarded. The nursing department will be responsible for cleaning the refrigerator & will be in-serviced on their responsibility for cleaning the refrigerator & monitoring the dates on the resident's snacks that as sent out. The dietary department will be reminded in an in-service that all items going out to the nourishment rooms must be dated. The nursing & administrative managem staff will monitor the dining delivery set to residents for 1 month to ensure the stausing appropriate methods when setting residents' trays for their meals. Any advindings will be addressed/corrected immediately. The dietary manager will monitor her staff for 1 month to ensure the are following appropriate handwashing techniques & appropriate handwashing techniques & appropriate frying technique will be addressed/corrected immediately. Their findings will be reviewed by the QAPI/IDT weekly meeting for 1 month.	ent rvice iff are up erse hey	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			DNSTRUCTION		S SURVEY PLETED
		445256	B. WING		11/15/2017		
	PROVIDER OR SUPPLIER	T CENTER		649 N	ET ADDRESS, GITY, STATE, ZIP CODE ICMURRY BLVD TSVILLE, TN 37074	-	17120
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI IAG	ζ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	85	(X5) COMPLETION DATE
	F hall. Continued of returned to the Dieta and failed to wash of donning gloves and the beverage area a observation reveale gloved hand to oper obtained bulk sliced observation reveale of the bulk cheese very pulling a piece of sligloved hand; then libbologna sandwich; bologna; put the breathe sandwich on a pulling a piece of sligloved hand; then libbologna; put the breathe sandwich on a pulling a piece of sligloved hand; then libbologna; put the breathe sandwich on a pulling with the Critinary of the sandwich on a pulling with the Difailed to remove conher hands prior to donni beverages and food interview with the Difailed to remove conher hands prior to he bread for resident us. Observation on 11/1 Dietary Department (DM) present reveal prep table and used Continued observatilids were not dry. Continued observation, Continued of the drying. Continued of the drying. Continued of the donather and placed immediately after water and placed immediat	rs dining room and the E and pservation revealed they ary Department at 5:33 PM or sanitize their hands prior to plating food and drinks from and steam table. Further d the Dietary Aide used her in the reach in cooler and cheese. Continued d she touched multiple slices with her left gloved hand while ced cheese with the right fited a slice of bread from a placed the cheese on the rad back on top; and placed plate. The Dietary Aide #1 on in the Dietary Department d to wash or sanitize their ing gloves and serving for the residents. Further etary Aide confirmed she attaminated gloves and wash andling bulk cheese and see. 4/17 at 1:45 PM in the with the Dietary Manager ed 9 plate lids stacked on the during the lunch meal, on revealed the inside of the ontinued observation revealed vere stacked against one on the drying rack ashing and rinsing without air pservation revealed soup on top of each other and were	F3	71			

(2 V) trains comme

STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED
		445256	B. WING_		11/15/2017
	PROVIDER OR SUPPLIED			STREET ADDRESS, CITY, STATE, ZIP CODE 649 MCMURRY BLVD HARTSVILLE, TN 37074	(
(X4) ID PREFIX TAG	/EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 371	Conlinued From p	age 13	F 37	1	
	the Dielary Depart	DM on 11/14/17 at 1:48 PM in the lacility dequate space or drying racks ompletely prior to resident use.			
	11/14/17 at 2:15 P revealed pink shin ice machine. Furth nourishment refrig with the DM prese debris on the refrig Continued observa-	e Ice machine on C Hall on M with the DM present y debris on the Inside top of the ner observation of the erator on the F hall at 2:40 PM nt revealed greenish/black gerator and freezer seal. etion revealed orange shiny alle glass shelf of the refrigerator ms available for resident use.	120		
	the F hall nourished	DM on 11/14/17 at 2:45 PM in nent room confirmed the facility a clean and sanilary ice ishment refrigerator for the			
	hall on 11/14/17 at revealed two 8 our 11/13/17; one 4 our updated; and four	nourishment refrigerator on E 2:30 PM with the DM present nce carlons of buttermilk dated nce souffle cup of applesauce and one half peanut butter ed available for resident use.			
F 515	the E hall nourishin falled to dispose of to date applesauce available for reside	RESIDENT CLINICAL	F 61	5	

12 27 THEFT COME.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		445256	B. WING		11/15/2017			
NAME OF	PROVIDER OR SUPPLIER	60) KO. 15	1.	8	TREET ADDRESS, CITY, STATE, ZIP CODE			
ተተለ መምርነ	ULLE CONVALERCEN	T CENTER		G	49 MCMURRY BLVD			
HARTSVILLE CONVALESCENT CENTER				HARTSVILLE, TN 37074				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID IPREFI TAG		PROVIDER'S PI.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DAYE	
F 515	Continued From pag	ge 14	Fe	F 515 Medical records will be retained for the				
	(i) Medical records.			į	period of time required by State law: or five years from the date of discharge whe	213		
	` .	must be retained for-			there is no requirement in State law; or for a minor. 3 years after a resident reach	1		
	(i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or				legal age under State law, 1. The facility ADL flow sheets policy wil	5		
Ì					be changed from retaining the flow sheets for 30 days to retaining the flow sheets for			
(lii) For a minor, 3 years after a resi			3 months (90 days). 2. The nursing stuff will be in-service			12-31-17		
			i	ì	changing the ADL flow sheets retention			
i	This REQUIREMEN	T is not met as evidenced		į	time 3.The DON & MDS coordinator will mon	itov		
į	by:			:	the ADL flow sheet time frame retention	1107		
ì	Based on review of review, and interview	facility policy, medical record		i	change to ensure the look-back time for			
	maintain resident clir				completing the MDS process is sufficient, if not sufficient, the retention time will be			
}	appropriate time fran			- 1	changed			
İ	The findings included:				4. The change in retaining the ADL flow si will be reviewed after the 90-day retention	n		
į	= 0			1	change to ensure the look-back time frame supports an appropriate look-back time for			
į	Review of facility poli	cy, ADL (Activities of Daily dated 1/15/16 revealed			the MDS process			
į	" ADL flowsheets ar	e collected by the DON		1				
i	(Director of Nursing)	at the end of each month,		1				
i	and kept in the DON	office for 30 days. At the end		1				
1	of the 30 day period, and a new 30 day co	all flow sheets are shredded		İ				
1								
	Resident #5 was adn	nitted to the facility on 4/7/04		- 1		Ŷ		
	and readmitted 6/10/ Type I Diabetes Melli	15 with diagnoses including lus. Type II Diabetes		1				
	Mellitus, Cataracts, H	lypertension, Peripheral		ļ		ì		
1.	Vascular Disease, Ed	lema, Arthropathy, Long		į		Į.		
į (Torm Use of Insulin, I Atherosclerotic I-loart	lear I-allure,				Į.		
1	Ameroscierotic meant Obstructive Pulmonal	ry Disease, Bipolar Disorder,		1				
*1	Moderate Intellectual	Disabilities, Peptic Ulcer,						
1	and Gastro-Esophage	eal Reflux Disease.			AL ALBERTA CONTROL			

		AND HUMAN SERVICES		4200	FORM	11/28/2017 NAPPROVED . 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		445256	D. WING _			15/2017
NAME OF PROVIDER OR SUPPLIER HARTSVILLE CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 649 MCMURRY BLVD HARTSVILLE, TN 37074	DE	
(X4) ID PREFIX TAG	! (FACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID ! PREFIX ! TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 515	Continued From pa	ge 15	F 51	15		
	Review of the Quarterly Minimum Data Set (MDS) dated 6/2/17 revealed Resident #5 had a Brief Interview for Mental Status score of 3, indicating severe cognitive impairment. Resident #5 required supervision for transferring, walking in room/corridor, locomotion on/off unit, eating; required extensive assistance with dressing, toileting and Activities of Dally Living (ADLs) and utlized a walker. Review of the Quarterly MDS dated 9/1/17 revealed the resident had impaired vision and did not have corrective lenses. Resident #5 required limited assistance for bed mobility and eating; required supervision to walk in room/corridor and utilized a walker, locomotion on/off unit, transfers and dressing; required extensive asssistance for toileting and ADLs. Medical record reveiw revealed there were no ADL flowsheets for the months prior to October 2017.					
	the 2nd floor nurses	ON on 11/14/17 at 3:05 PM at station revealed the facility Flowsheets once the MDS of the information needed for ar 30 days.	÷			
	11/14/17 at 4:25 PM	sed Practical Nurse #2 on I at the 2nd floor nurses a utilized the ADL flowsheets S.				
	5:25 PM in her office destroyed the ADL for confirmed the facility	dministrator on 11/15/17 at e revealed the facility lowsheets after 30 days and y failed to maintain resident he appropriate time frame.				

TZ OT BENEZISTER SCHOOL